Summary Of Benefits - Other Covered Benefits

Connecticut General Life Insurance Co.
For Employees of Brookhaven Science Associates
Open Access Plus Plan

Selection of a Primary Care Provider - Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.
For children, you may designate a pediatrician as the primary care provider.

Maximum Reimbursable Charge (applies to Non-Participating Providers) - Out-of-network services are subject to a Calendar Year Deductible and Maximum Reimbursable Charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile (80%) of charges made by health care professionals of such service or supply in the geographic area where it is received. These charges are compiled in a database selected by Cigna. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable Deductibles, Co-payments and Co-insurance.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description – the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

Benefit	Your cost if you use a		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Lifetime Maximum	Unlimited		
Pre-Existing Condition Limitation (PCL)	Not applicable		
Calendar Year Deductible	Individual/Person: None Family: None	Individual/Person: $1,000 Family: $3,000	• The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles. • After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the co-insurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the co-insurance level specified by the plan. • Retail and mail order pharmacy costs contribute to the pharmacy plan deductible.
Calendar Year Out-of-Pocket Maximum	Individual/Person: $0 Family: $0	Individual/Person: $3,500 Family: $10,500	• The amount you pay for all covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums. • Plan Deductibles do not contribute toward your out-of-pocket maximum • Co-pays and benefit deductibles do not contribute towards the out-of-pocket maximum. • Mental health and substance abuse covered expenses contribute towards your out-of-pocket maximum. • After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
Routine Preventive Care - All Ages • Includes well-baby, well-child, well-woman and adult preventive care	Plan pays 100%	30% coinsurance* for well-baby and well-chld care. Not covered for well woman or preventive care	• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.

Short-Term Rehabilitation (Physical, Occupational, Cognitive and Speech therapy)	PCP $20 per visit SPEC $30 per visit	30% co-insurance *	• Unlimited days maximum per Calendar Year for all therapies combined; including chiropractic care • Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum • Cardiac Rehabilitation: 60 days maximum per Calendar Year
Breast Feeding Equipment and Supplies	Plan pays 100%	30% co-insurance *	• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies
External Prosthetic Appliances (EPA)	Plan pays 100%	30% co-insurance *	

* - after plan deductible is met

Place of Service - You pay based on where you receive services.										
	Physician's Office		Outpatient Facility		Emergency Room/ Urgent Care Facility		Independent Lab		Inpatient Hospital Facility	
Benefit	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Lab and X-ray	PCP $20 SPEC $30	30% co-insurance *	Plan pays 100%	30% co-insurance *	Plan pays 100%		Plan pays 100%	30% co-insurance *	Included with Inpatient Hospital charges	Included with Inpatient Hospital charges
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)	Plan pays 100%	30% co-insurance *	Plan pays 100%	30% co-insurance *	Plan pays 100%		Not Applicable	Not Applicable	Included with Inpatient Hospital charges	Included with Inpatient Hospital charges
TMJ, Surgical and Non-Surgical	PCP $20 SPEC $30	30% co-insurance *	Plan pays 100%	30% co-insurance *	Not Applicable		Plan pays 100%	30% co-insurance *	Plan pays 100%	Plan pays 100%
Non-Surgical: Unlimited maximum per Lifetime										
Infertility	PCP $20 SPEC $30	30% co-insurance *	Plan pays 100%	30% co-insurance *	Not Applicable		Plan pays 100%	30% co-insurance *	Plan pays 100%	Plan pays 100%
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.										
$15,000 lifetime maximum										
Family Planning - Men's Services	PCP $20 SPEC $30	30% co-insurance *	Plan pays 100%	30% co-insurance *	Not Applicable		Plan pays 100%	30% co-insurance *	Plan pays 100%	Plan pays 100%
Includes surgical services, such as vasectomy (excludes reversals).										
Family Planning - Women's Services	Plan pays 100%	30% co-insurance *	Plan pays 100%	30% co-insurance *	Not Applicable		Plan pays 100%	30% co-insurance *	Plan pays 100%	Plan pays 100%
Includes surgical services, such as tubal ligation (excludes reversals). Contraceptive devices as ordered or prescribed by a physician										

* - after plan deductible is met

Benefit	Your cost if you use a		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Acupuncture	SPEC $30	30% co-insurance *	Unlimited days maximum per Calendar Year
Hearing Aids	Plan pays 100%	30% co-insurance *	• $2000 maximum per 1095 days
Wigs	Plan pays 80%	30% co-insurance *	• One per lifetime if hair loss is due to radiation or chemotherapy

What's Not Covered (*not all-inclusive*):
Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Cosmetic services
- Custodial and other non-skilled services
- Dental care, unless due to accidental injury to sound natural teeth or otherwise outlined in "Covered Expenses"
- Experimental, investigational or unproven services
- Eyeglass lenses and frames, contact lenses and surgical vision correction
- Genetic screenings
- Non-prescription and anti-obesity drugs
- Reversal of sterilization procedures
- Services for an injury or illness that occurs while working for pay or profit including services covered by worker's compensation benefits
- Services provided through government programs
- Services that are not medically necessary
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit (eVisits)
- Weight loss programs

Summary of Benefits and Coverage Supplement